Welcome

Patient Information

Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink. Should you have any questions or concerns, please do not hesitate to ask for assistance. We will be happy to help.

Name: ____Date: ______________

Address: __________________________ City: _________ State: _____ Zip code: _________

Sex: Male / Female Date of birth: _______________ Email: _________________

Home Phone: _______________ Cell Phone: _________________ Work phone: _________

Employer/School: ________________________________ Occupation ___________________

Spouse or parent's name: ________________ Employer _____________ Work phone: ________

Whom may we thank for referring you to us? ____

Person to contact in case of emergency ____________________ Phone: ____________________

Responsible Party (Fill this section out if you are under the age of 18)

Name of person responsible for this account ______________________________________

Relationship to patient _________________________________ Phone: _______________

Address ______________________________City: _________ State: ____ Zipcode: _______

Insurance Information

Name of subscriber_________________________Relationship to patient: self / spouse / parent

Subscriber's Address________________________ City ____________ State ______ Zip ________

Subscriber's Date of birth: __________________________Subscriber's Social Security#__________

Subscriber's Employer ______________________ work phone _________________________

Insurance Co. ______________ Phone ______________ Group # _______ Member ID#:__________

Insurance Address ___________________________ City ________ State ______ Zip__________

How much is your deductible? __________ How much have you used? _____________________

Do You Have Additional Insurance? Yes / No If yes, please complete the following:

Name of subscriber_________________________Relationship to patient: self / spouse / parent

Subscriber's Address________________________ City ____________ State ______ Zip ________

Subscriber's Date of birth: __________________________Subscriber's Social Security#__________

Subscriber's Employer ______________________ work phone _________________________

Insurance Co. ______________ Phone ______________ Group # _______ Member ID#:__________

Insurance Address ___________________________ City ________ State ______ Zip__________

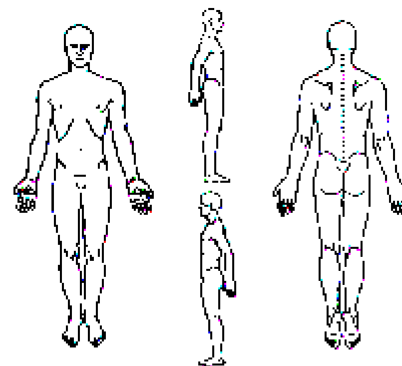
How much is your deductible? __________ How much have you used? _____________________

Describe Your Current Problem And How It Began:

Mark an "X" on the picture where you have pain or other symptoms.

Headache Neck pain Mid-back pain Lower back pain

Other ____



Is this problem work related / Auto related / None

Date Problem Began: ______________________________

How Problem Began: ______________________________

Have you been treated for this problem? ____________

Current Pain level (0=no pain, 10 = worst pain imaginable)

0 1 2 3 4 5 6 7 8 9 10

How often are you r symptoms present? (Circle one)

0-25% 26-50% 51-75% 76-100%

In the past week, how much has you pain interfered with your daily activities (i.e. social acitivites, house hold chores, work, etc.)?

Current Pain level (0=no interference, 10 = unable to do carry on any activities)

0 1 2 3 4 5 6 7 8 9 10

Have you had spinal x-rays, MRI, CT-Scan for your areas of complaint? ___ Yes ___ No

Date(s) taken: ______________________________ What areas were taken? ____________

Please check all of the following that apply to you:

Recent fever
High blood pressure
Corticosteroid use (cortisone, prednisone, etc.)
Numbness in groin/buttocks
Osteoporosis
Prostate problems
Urinary problems
Abnormal weight gain / loss
Pain unrelieved by position or rest
Surgeries ________________________
Medications: ________________________

Diabetes
Stroke (date) __________
Taking birth control pills
cancer / tumor (explain) ______________
Epilepsy / Seizures
Menstrual problems
Currently pregnant # weeks _____
Marked morning pain/stiffness
Pain at night
visual disturbances
Dizziness/fainting

Family History

Cancer Diabetes High Blood Pressure

Heart Problems/ Stroke Rheumatoid arthritis

PLEASE READ AND SIGN BELOW:

I certify to the best of my knowledge, the above information is complete and accurate. I understand the clinic will verify my insurance coverage, however if the health plan information received from the insurance carrier is not accurate, or if I am not eligible to receive health care benefits through this provider, I understand that I am liable for all charges for services rendered. I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my doctor of chiropractic may need to contact my medical doctor if my condition needs to be co-managed. Therefore, I give authorization to my chiropractor to contact my physician, if necessary.

Patient Signature: ________________________________ Date: ______________